The Fully Functional Service Delivery Point in Afghanistan: A Baseline Evaluation

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LIST OF ACRONYMS / ABBREVIATIONS

AED	Academy for Education and Development
AQS	Access to Quality Services
BHC	Basic Health Center
BPHS	Basic Package of Health Services
CAAC	Cachment Area Annual Census
CBHC	Community Based Health Care
CHC	Comprehensive Health Center
CHW	Community Health Worker
DH	District Hospital
EPI	Expanded Program on Immunization
FFSDP	Fully Functional Service Delivery Point
HF	Health Facility
HMIS	Health Management Information system
IEC	Information, Education, and Communications
IMCI	Integrated Management of Childhood Illness
MAAR	Monthly Aggregated Activity Report
MIAR	Monthly Integrated Activity Report
MOPH	Ministry of Public Health
MSH	Management Sciences for Health
NGO	Non-governmental Organization
PPHCC	Provincial Public Health Coordination Committees
PPHO	Provincial Public Health Office
PSS	Provincial Support and Strengthening
REACH	Rural Expansion of Afghanistan Community-based Health Care
TA	Technical Assistance
TAI	Technical Assistance, Inc.
TB	Tuberculosis
T&E	Training and Education
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development

Background

The Rural Expansion of Afghanistan's Community-based Healthcare (REACH) Program was launched May 16, 2003, by Management Sciences for Health (MSH) under contract to the United States Agency for International Development (USAID) to address the health of women of reproductive age and of children under age five. The REACH strategic objective is to increase the use of basic health services by these two target groups.

Four REACH technical programs – Access to Quality Services (AQS), Ministry of Public Health (MOPH) Capacity Building, Provincial Support and Strengthening (PSS), and Training and Education (T&E) – conduct activities designed to foster the strategic objective by achieving three intermediate results: (1) expanded access to quality Basic Package of Health Services (BPHS), (2) improved capacity of individuals, families, and communities to protect their health, and (3) strengthened health systems at the national, provincial, and district levels. Through its grants program, REACH supports 19 non-governmental organizations (NGO) to provided the BPHS in 14 provinces throughout Afghanistan.

REACH has introduced the Fully Functional Service Delivery Point (FFSDP) tool in Afghanistan to encourage behavior change on the part of medical staff at the clinic level, who are very clinically and curatively oriented and thus give little attention to management tools and preventive practices that can help to improve service delivery. FFSDP introduces a set of standards which help clinic staff systematically focus on expanding Basic Package of Health Services (BPHS) coverage to target groups in the health facility's catchment area and raising the quality of basic health services.

NGO and MOPH clinical and managerial staff have received the FFSDP methodology with enthusiasm. They see the FFSDP as a useful guide that helps them put together the pieces of the service delivery puzzle and introduce basic management systems wherever they are lacking (for example, a basic drug/and supplies surveillance system).

Changing the behavior of facility staff takes time. Behavior change requires sustained support before the changes can be integrated into day-to-day practice. The FFSDP is implemented in six-month cycles and builds on regular encounters among facility staff, the director of the facility, the NGO supervisors, and REACH technical staff, during which the needed changes are reiterated and further progress can be planned.

Introduction

So far, 205 of the 219 health facilities run by Round 1 and 2 grantees have been evaluated using the FFDDP methodology. In total, 207 persons have been trained as facilitators to introduce FFSDP standards of quality in the health facilities. Of these, 149 are NGO staff, 11 are central level Ministry of Public Health (MOPH) staff, 20 provincial level MOPH staff and 27 are REACH program staff.

The present report is based on the results of the FFSDP baseline evaluation conducted between February 2005 and July 2005 in 180 [1] REACH-supported health facilities (Rounds 1 and 2 NGO grantees) operating in 11 REACH-supported provinces. As might be expected, baseline results show low scores for meeting many of the standards of quality included in the FFSDP: nothing is in place, forms are in place but not in use and/or planned activities are not being performed. Most standards get a positive score when forms and procedures are in place **and** used and when activities are planned **and** performed as planned.

Implementation Framework

An implementation framework containing several mechanisms to manage the FFSDP process has been introduced:

1. During the first six-month cycle, REACH performs two **external evaluations**, one at the beginning and one at the end of the phase. In-between these two external evaluations, the NGO performs two formal **internal evaluations** and also conducts ongoing supervision, making visits to assist the clinic staff in introducing necessary changes and to monitor progress.
2. Following each external evaluation, each NGO develops a **workplan** for the next six months improvement cycle. The workplan specifies the concrete corrective actions identified as necessary during the last external evaluation; it also names the person(s) responsible for taking the corrective action (clinic staff, NGO manager, and REACH staff).
3. A **Provincial FFSDP Support Committee,** comprised of the NGOs implementing the FFSDP in their health facilities, staff of the Provincial Public Health Office (PPHO) and REACH field office staff, oversees and coordinates FFSDP implementation in each province. The field staff also prepares summary reports of evaluations to inform the Provincial Public Health Coordination Committee (PPHCC) members of progress made.
4. In each REACH-supported province, three **Model FFSDP Health Facilities** are provided more intensive TA to accelerate the implementation of FFSDP standards. At the same time, a replication strategy for the other health facilities in the province is developed to allow them to benefit from the example of the model health facilities.
5. Through regular joint monitoring visits, the **PPHCC members monitor the quality** of improvements in the health facilities using a monitoring checklist that includes the key standards of the FFSDP tool.

[1] The results of the baseline evaluation which was conducted in July 2005 in Badakhshan and Paktia are not yet available and the baseline evaluation in Ghor is planned for October 2005. Nine facilities have not been evaluated due to security reasons (2 in Kandahar and 7 in Paktika).

General comments on the results of the baseline evaluation:[2]

1) The results of the baseline evaluation in 180 health facilities are similar to those in the demonstration project conducted from June to December 2004 in nine health facilities of three participating NGOs (Figure 1), showing that the tool has been well adapted to the Afghan context. While standards based on the availability of resources certainly need improvement (particularly appropriate female staffing), adequate management support systems and a systematic approach to Community-based Health Care are lacking across the board.

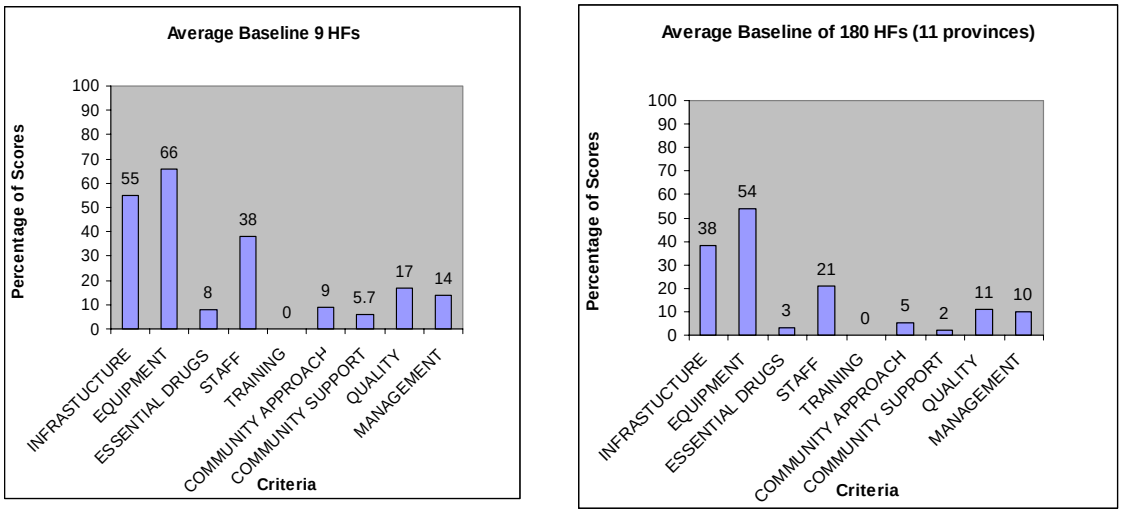


Figure 1

The average of the aggregated scores for the nine criteria varies little from one province to the other (**Figure 2**).

[2] Results of the baseline evaluation for selected standards are in Annex 1.

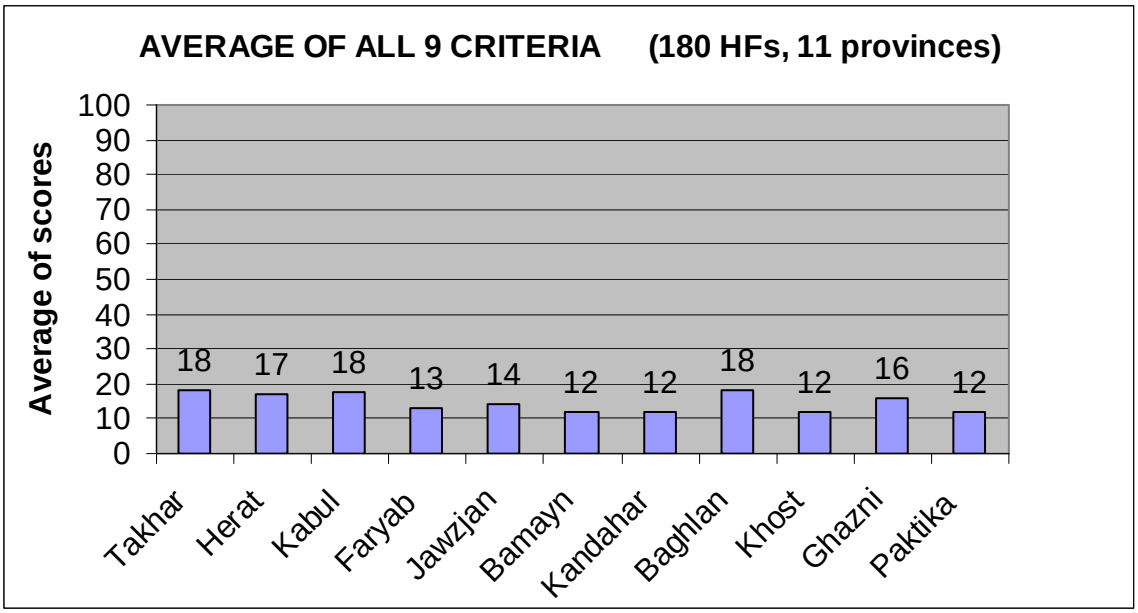


Figure 2

While the baseline evaluation reflects common weaknesses in the quality of services offered at the health facility level, it is expected that the second external evaluation will show differences in improvements among facilities, among NGOs or among provinces. Each health facility staff, NGO headquarters, and/or PPHCC will have made varying levels of progress in

- Optimizing available resources not used properly at the time of the baseline
- Developing basic management support systems where they were lacking, and
- Acquiring knowledge and experience in applying the national CBHC approach.

The results of the second external evaluation of the Demonstration Project (June – December 2004) clearly illustrate differences in progress among the concerned NGOs.

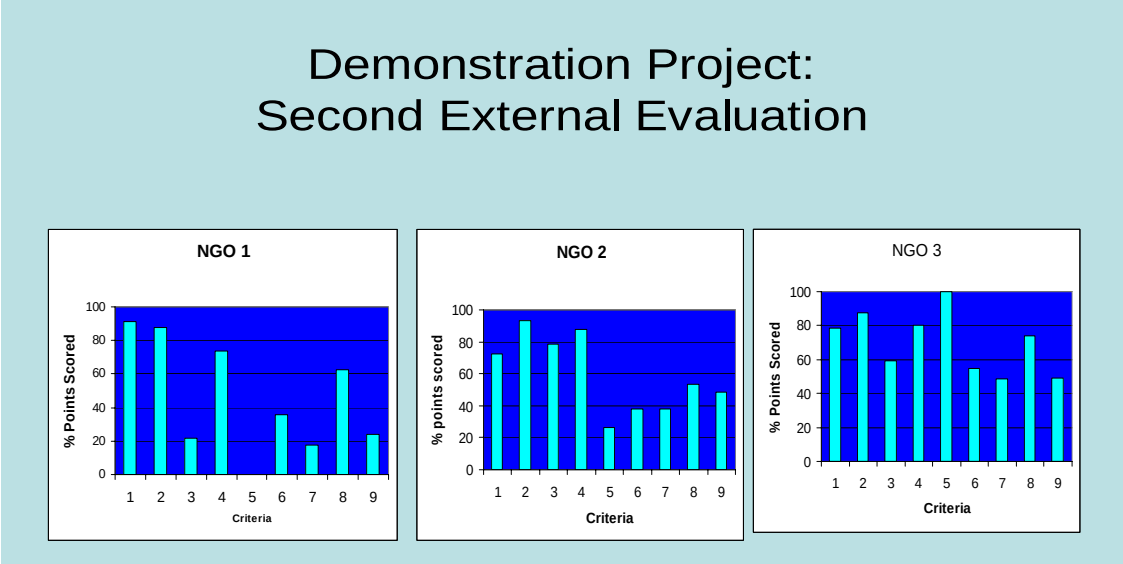


Figure 3

2) Very few NGOs seem to readily distribute the information necessary for the health facility staff to set annual and monthly goals for health care delivery. Since ample technical assistance has been delivered to NGO headquarter staff on implementation of the Catchment Area Annual Census (CAAC) and baseline household survey, one might have expected that by the time of the FFSDP baseline evaluation, either CAAC would have been implemented or the results of the baseline household survey, with appropriate targets for each facility, would be available at each facility. Likewise, during the period February 2005 to July 2005, only 35 facilities out of 180 showed evidence that IEC material addressing the three major BPHS priorities was available and being used by staff at the health facility. Improving the flow of information from NGO headquarters to the facility level seems to be a priority.

3) Some standards seem easier to attain than others. Some Provincial FFSDP Support Committees have readily and successfully promoted the use of standardized signs indicating the services available in the facilities or referral slips for illiterate Community Health Workers (CHW). The FFSDP tool proposes examples of several formats that can facilitate setting up basic management support systems. The pharmaceutical stock control card has been adopted by most NGOs, but an individual patient record card has not yet been generally introduced.

4) Several FFSDP standards assume that CHWs are posted around the facility and supplied with drugs and equipment. At the time of the baseline evaluation, this was not yet the case for many facilities. This situation should improve during the next six months as many CHWs have now been posted. However, improvement on CHW-related standards will greatly depend on the availability and performance of the new Community Health Supervisors. Having this new position at the health facility should facilitate the linkage between the health facility, the CHWs, and communities.

One of the most striking findings is the lack of linkage between health facility activities and the community. The concept of Community-based Health Care (CBHC) is somewhat understood intellectually (or "culturally") by the facility staff but is not applied in a formal and effective way. It is expected that the on-going posting of a critical mass of trained and equipped CHWs and the availability of Community Health Supervisors will make a difference. Application of the Community Leadership Guide, developed by REACH, is also expected to make a difference. But here again, the managers of the NGO headquarters, who have been trained, have an important role to play in replicating this training with the health facility staff and their surrounding communities.

General Conclusions

So far, the FFSDP tool has been received positively by the NGOs as a good supervision tool for supervisors and staff in charge of the health facilities, and as a practical monitoring tool for the PPHCC members. The second external evaluation (and the third evaluation for some provinces before the end of the present REACH project) will allow the NGOs to monitor the effects of their efforts to increase coverage of the target population with quality basic health services at the local level and will allow the PPHCC to do the same at the provincial level.

As a tool, the FFSDP is flexible. When standards are met by the majority of the health facilities, they can be replaced by more sophisticated standards according to the evolution of the quality of the services delivered in Afghanistan.

Some Recommendations

- NGOs headquarters should "decentralize" the knowledge and material they receive from REACH and extend it to the health facility level. In particular, clinic staff should receive on-the-job training in the appropriate use of the results of the baseline household survey conducted in their catchment area and of the results of the CAAC, wherever it has been performed. Unless this is done, facility-based staff will not be able to adequately monitor progress in the coverage of the catchment area population with the BPHS.

- Strengthening and widening the supportive framework that underpins the expected behavioral changes of the health staff will be key in actually improving the quality of basic heath services in Afghanistan. Well-targeted and timely technical assistance from REACH staff to NGOs and from NGO managerial staff to health facility staff needs to be sustained.

- The Health Management Information System (HMIS) Task Force and the Monitoring and Evaluation Advisory Board of the MOPH should contribute to the development of a national individual patient record card to facilitate the delivery of integrated health care at the health facility level. This would help in reducing

the significant number of missed opportunities to integrate services during a client visit, particularly in immunization and family planning services.

Lessons Learned

Introducing the FFSDP in all health facilities of the Rounds 1 and 2 grantees in 11 REACH-supported provinces in a period of 6 months has demanded a tremendous effort from REACH. Close collaboration between the central REACH FFSDP team and REACH field offices as well as the support of other REACH departments has been key in achieving this task. It is clear that several provinces could benefit from having a provincial office to support provincial strengthening, including the roll-out and institutionalization of the FFSDP. The physical conditions in Afghanistan have often proven too challenging to enable one field office to adequately cover several provinces.

The introduction of the FFSDP must be timed carefully. Certain minimal preconditions need to be fulfilled before the FFSDP can be implemented. In Afghanistan, a national policy and interim health strategy were clearly defined, including the Basic Package of Health Services (BPHS) and a CBHC approach. The NGO grants and contracting schemes provided a common framework for several interventions (CHW training, midwives/community midwives training, the national Health Management Information System, a baseline Household Survey, Community Mapping, Community Leadership guide, and Gender Awareness, among others). With the finalization of clinical protocols for the interventions of the BPHS, and after a critical mass of service providers has been trained in their use, specific standards of clinical knowledge and practice will need to be incorporated in the near future.

In a post-conflict situation, in addition to the very visible destruction of infrastructure, the structural deterioration of civil society often leaves service providers without clear and common professional references. Both governmental and non-governmental agencies can benefit from a commonly accepted tool to evaluate quality of care. When adapted to the local situation, the FFSDP, which focuses on the service delivery point where the health system interacts with the community that should benefit from it, contributes to re-establishing vital links between the civil society and the government.

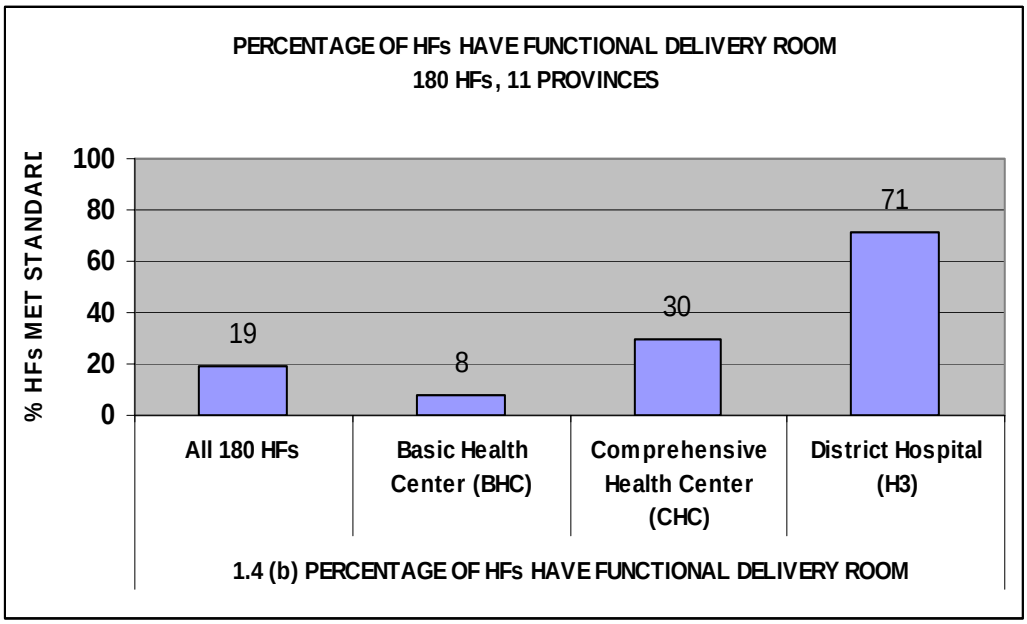
Annex 1: Baseline Evaluation Results for Selected Standards

The analysis of the data, based on the evaluation of 180 Health facilities, including

- 100 Basic Health Centers
- 73 Comprehensive Health Centers
- 7 First Referral Hospitals (also called "District Hospital H3")

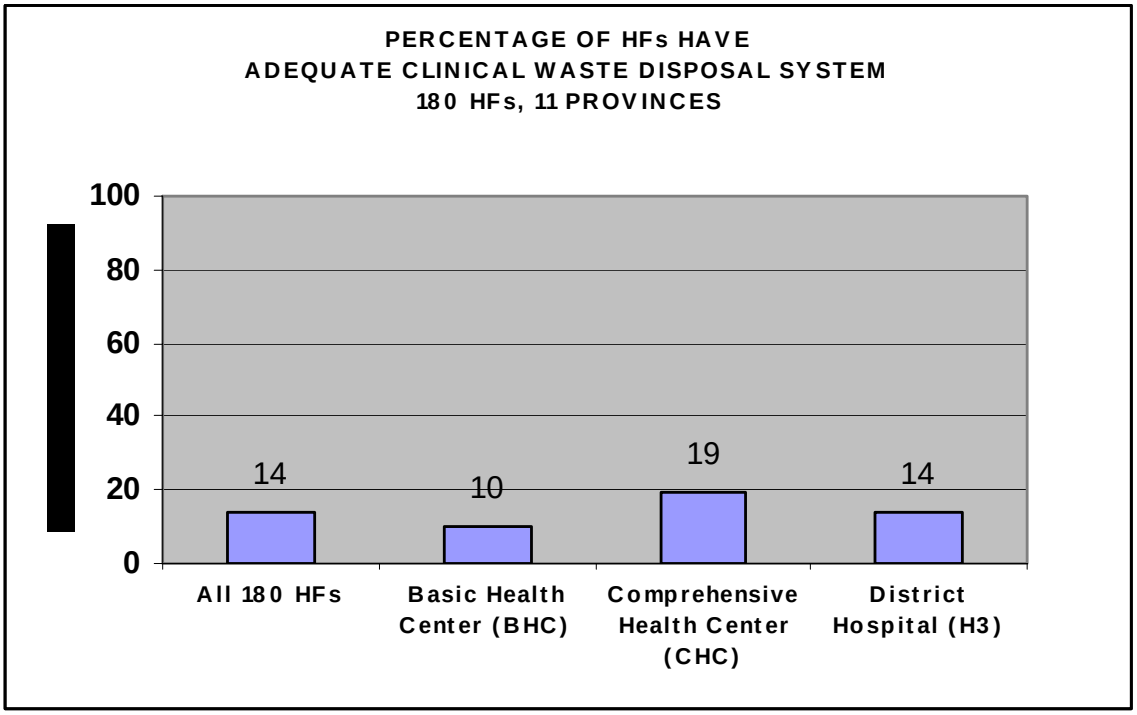
is presented in this annex.

1. Infrastructure



Annex Figure 1

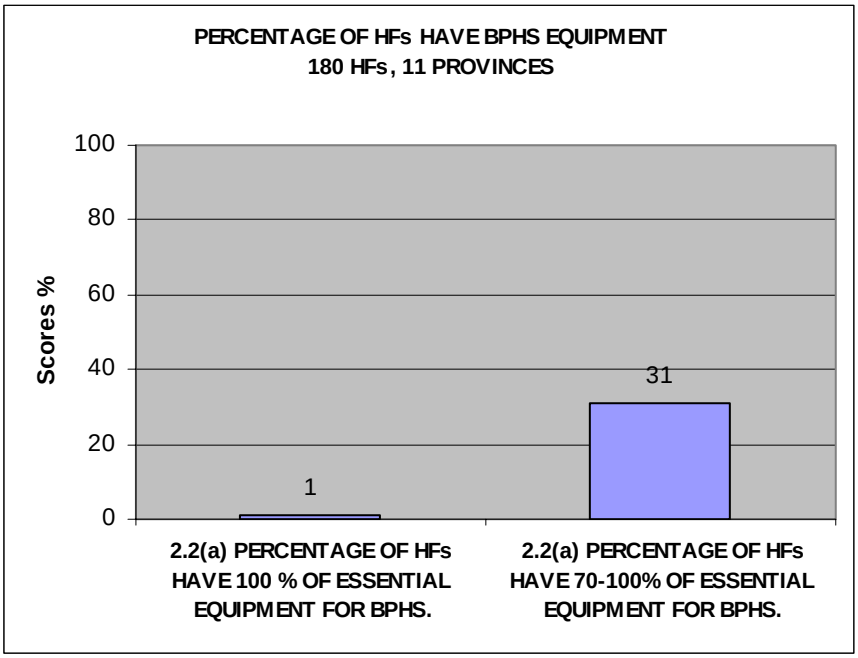
Percentage of health facilities having a functional delivery room (Annex Figure 1). Out of 180 health facilities 19% have an appropriate delivery room with minimum requirements, defined as: "bed –ideally a delivery bed, closed container of clean water with a bowl and soap for washing hands and a cleanable floor with a channel or drain. The room should be private with a lockable door and screenable windows. (Note: an area partitioned only by a curtain is not acceptable.)".
Of the 100 Basic Health Centers evaluated, 8% have a functional delivery room; 30% of the Comprehensive Health Centers and 71 % (5) District Hospitals have a functional delivery room at their disposal.



Annex Figure 2

Adequate disposal of clinical waste (Annex Figure 2). Only 14 % of the 180 health facilities practice adequate clinical waste disposal. Even where incinerators and pits are in place, clinical waste, including sharps, was seen in the immediate surroundings of the building. The good practice of adequate clinical waste disposal is lacking across the board. Dissemination of clear MOPH guidelines is definitively needed.

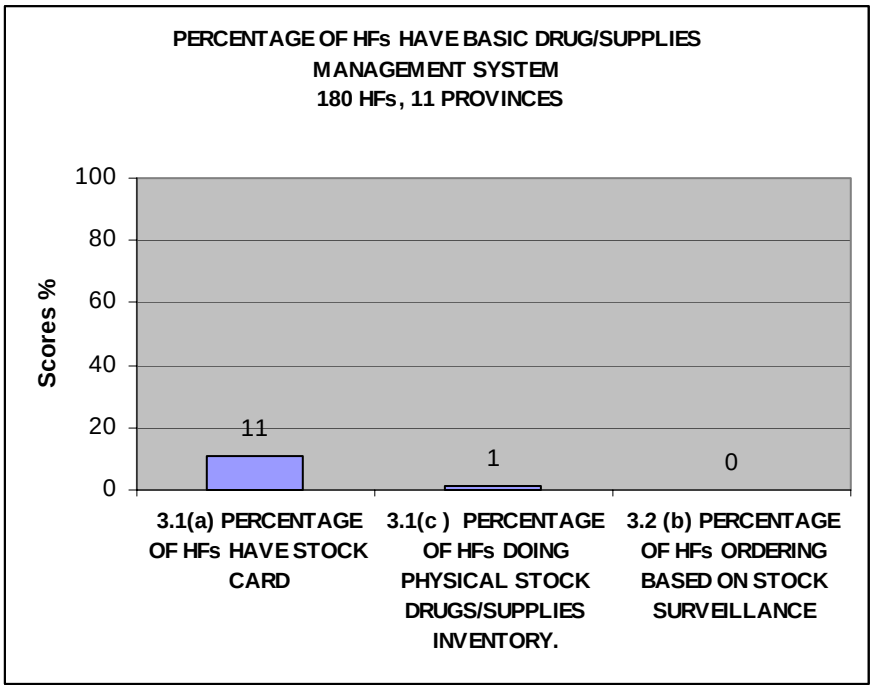
2. Equipment



Annex Figure 3

Availability of adequate equipment (Annex Figure 3). Only one percent of the 180 health facilities have a complete set of equipment as required by the BPHS. A total of 31% of the 180 health facilities have between 70% and 100% of the required equipment (25%, 36%, and 43% of the BHCs, CHCs and DHs, respectively).

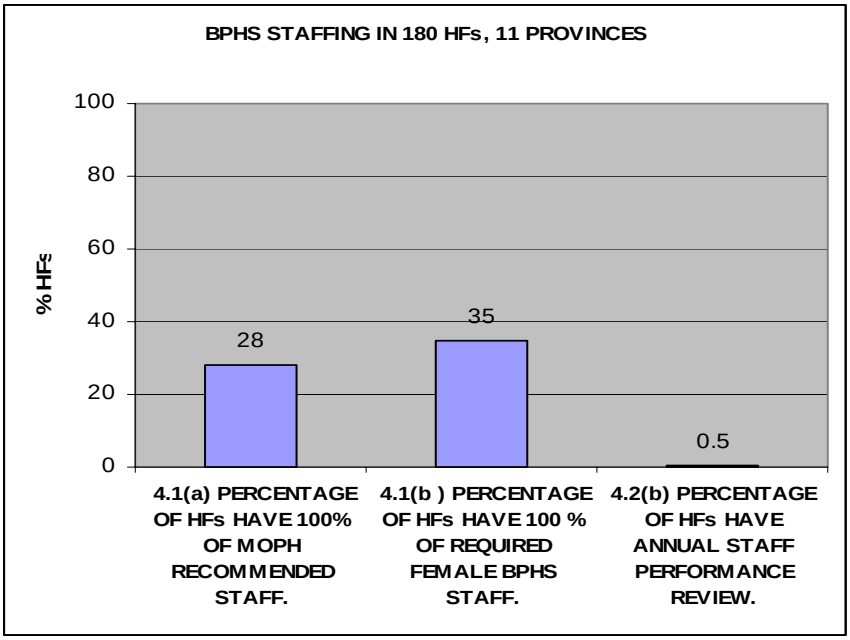
3. Drug/supply management



Annex Figure 4

Availability of a basic drug supply management system (Annex Figure 4). The FFSDP tool aims to guide the health facility staff in introducing a basic and sound surveillance and ordering system for essential drugs and supplies;11% of all health facilities have introduced a stock control card system. The NGO managers have been interested in adopting the stock control card concept and some had expanded its introduction in some of their health facilities even before the baseline evaluation was conducted. However, Annex Figure 4 shows that proper use of the stock control card by the pharmacist and performance of other essential activities, such as the physical inventory and ordering system, require significant further on-the-job training by the NGO FFSDP facilitator and by the REACH drug management unit.

4. Staff

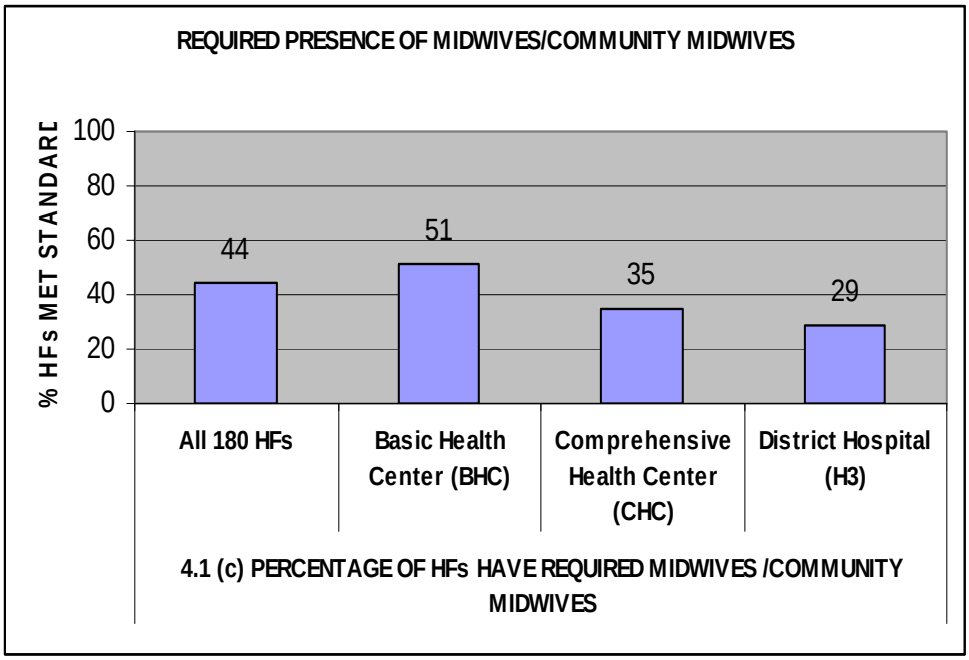


Annex Figure 5

Adequate staffing (Annex Figure 5). Staffing health facilities in rural areas according to the MOPH BPHS requirements is a major challenge. As shown in Annex Figure 5, only 28% of the 180 health facilities fully meet the requirement for male and female staff (38%, 16% and 0% of the BHCs, CHCs and DHs, respectively, met this standard).

Figure 5 shows that of the 180 health facilities, 35% fully meet the MOPH requirement for female staff (51%, 16% and 0% of the BHCs, CHCs and DHs, respectively, meet the standard).

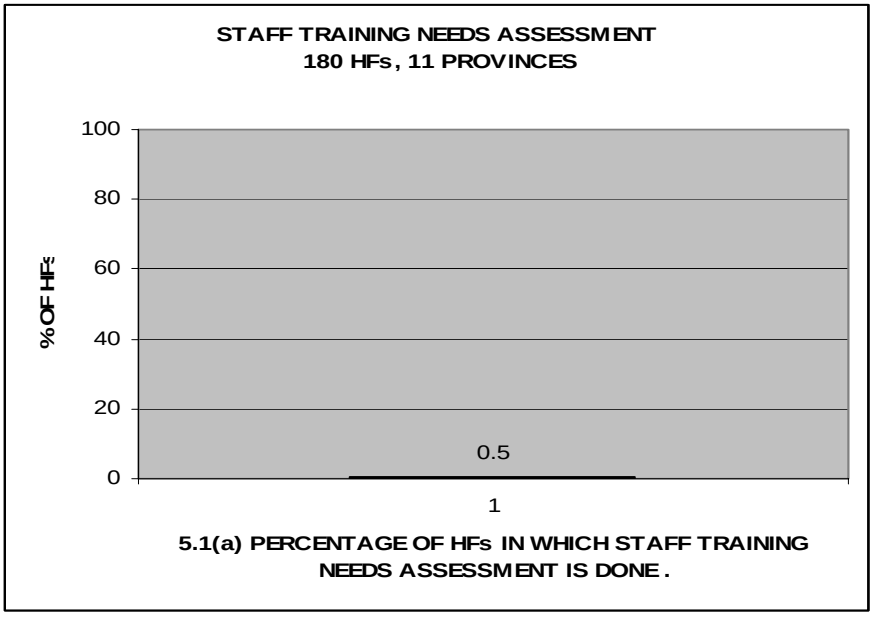
Very few (0.5%) staff receive a proper annual performance review in which their job description is reviewed, activities and expected achievements are discussed, and specific daily support and/or specific training needs are identified. The proposed revised MOPH national salary policy, which recognizes staff performance, may reinforce application of this last standard.



Annex Figure 6

Availability of required midwives and community midwives (Annex Figure 6). While 35% of the 180 health facilities (Annex Figure 5) have the full required female staff, Annex Figure 6 shows that 44% have the required number of midwives and/or community midwives. According to the BPHS, these are the only female positions required in the Basic Health Centers; thus the emphasis on posting midwives/community midwives in Basic Health Centers explains this relatively high rate. This interesting and promising finding should advocate for more training for midwives and community midwives.

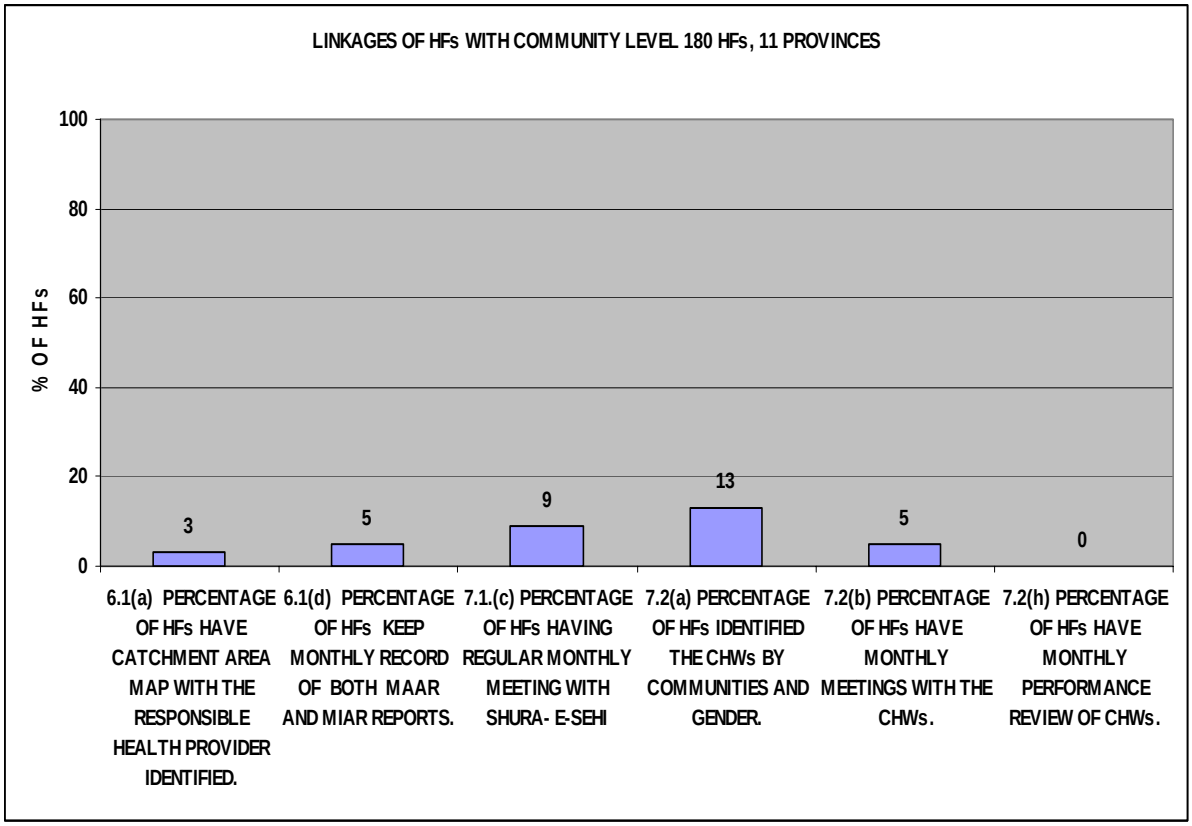
5. Training



Annex Figure 7

Staff training needs assessments (Annex Figure 7). Training activities are particularly centralized at the NGO training center. Annex Figure 7 shows that only 0.5% of health facilities are performing training need assessments, in which staff performance can be assessed and training activities proposed accordingly. This standard may improve once the on-going clinical refresher training of doctors and nurses has been completed.

6. And 7. Community Approach and Community Support



Annex Figure 8

Community Approach and Community Support (Annex Figure 8).

Catchment area map. Presently, 3% of the health facilities have drawn a map of their catchment area and identified the responsible health provider in each of the geographical sections. This information will facilitate the outreach activities of the health facility, for example, the organizing of "satellite clinics," where with the help of the CHW and his (her) community, an integrated health care package could be delivered by one vaccinator and the midwife of the health facility.

Required HMIS reports available at the health facility level. Five percent of the 180 health facilities are gathering the Monthly Aggregated Activity Reports (MAAR) and Monthly Integrated Activity Reports (MIAR) on a monthly basis. These reports contain records of all patients seen per service and per month within the catchment area (services provided by the health facility staff and by the CHWs) and assist with monitoring the monthly service coverage against the monthly target. In many facilities we observed that the MAAR reports are gathered by the CHW supervisors/trainers and handed over

directly to the NGO headquarters (or NGO training center), thus by-passing the health facility. The new position of Community Health Supervisor, who is based in the health facility, should reverse this situation. Also, because the number of trained CHWs as well as the understanding of the implementation of the national HMIS are growing significantly at all levels, this indicator should improve within the coming months.

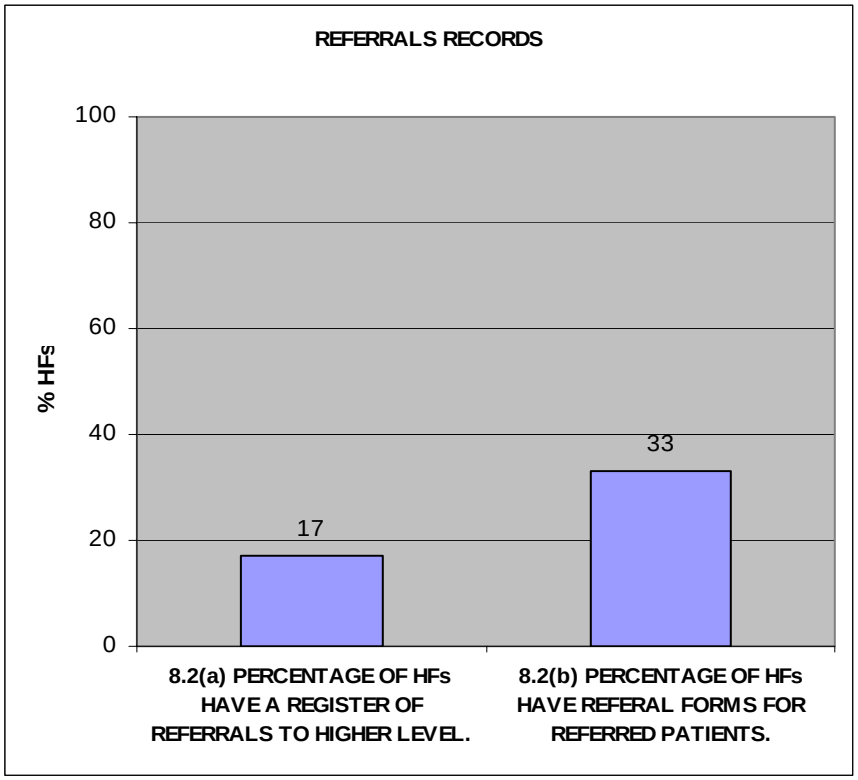
Regular and formal meetings with the *Shura-e-Sehi* (Community Health Committee). A total of 9% of the health facilities have regular meetings with the *Shura-e-Sehi* that are formalized by written minutes. To meet this standard, the members of the *Shura-e-Sehi* must be representative of the population of the catchment area.

The health facility has identified the Community Health Workers by communities and gender. Thirteen percent of the health facilities have developed a list of their surrounding CHWs according to the communities they serve and according to gender. (Some health facilities had not developed this list due to the lack of posted CHWs at the time of the baseline).

Monthly meeting at the health facility with the CHWs. Five percent of the health facilities are holding regular monthly meetings with the CHWs (2%, 11%, and 0% of the BHCs, CHCs and DHs, respectively, meet this standard). The meetings are important for (1) analyzing CHW performance by reviewing the Monthly Activity Report of each CHW or, if the CHW is illiterate, by reviewing the Pictorial Tally Sheet, (2) providing feed-back to each CHW on his/her performance; (3) planning activities for the next month; and (4) providing in-service training for the CHWs.

The Health facility is taking action to improve the performance of those CHWs who are not performing in providing the BPHS. The baseline evaluation found that no health facility is taking this responsibility. CHW trainers/supervisors have been expected to serve in this role. Now that the new position of the Community Health Supervisor exists, health facilities are expected to serve as a base for helping CHWs improve their clinical knowledge and also plan activities (particularly IEC and referral) in accordance with the activities of the health facility.

8. and 9. Quality and Management

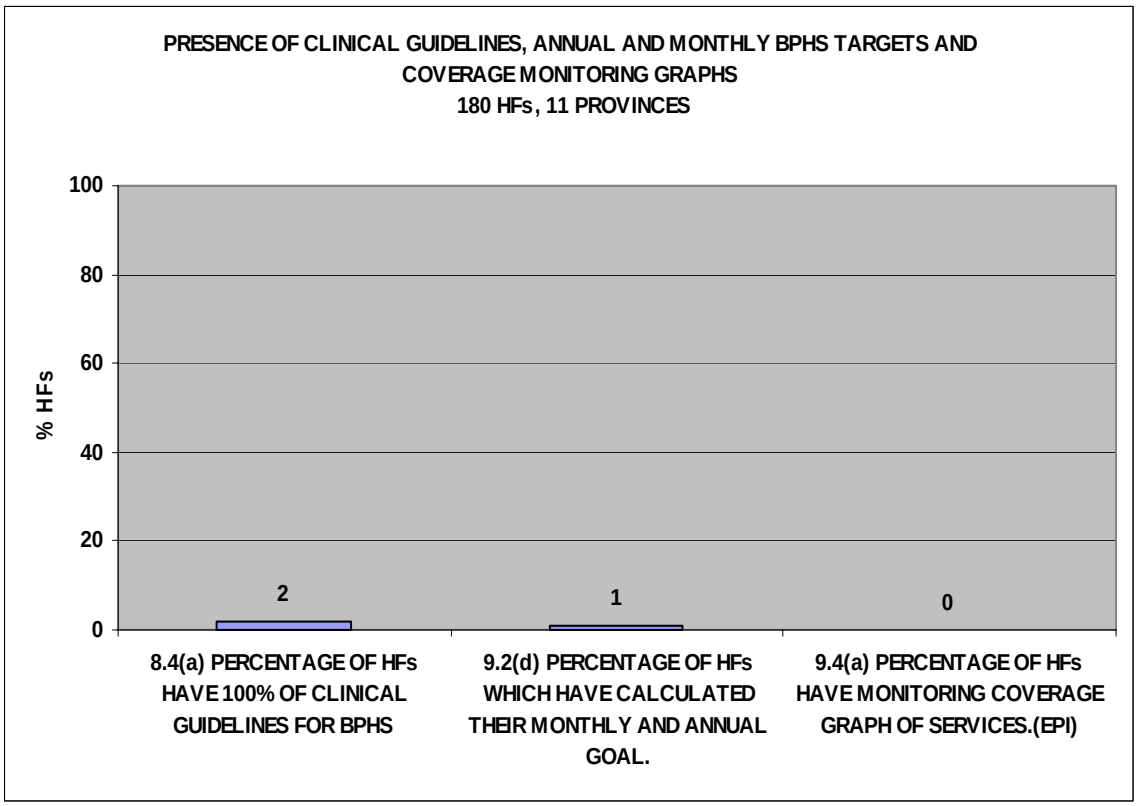


Annex Figure 9

Quality and Management indicators (Annex Figure 9)

Availability of a register of all referrals of patients to a higher level . Seventeen percent of the health facilities evaluated have such a system in place.

Referral forms to be sent with referred patients are available at the facility. Thirty-three percent of the 180 health facilities have proper referral forms. Facilities presenting forms that did not include basic clinical information (particularly vital signs and information on treatment provided before referral) were not scored. No significant difference on this standard was found among the different types of health facilities



Annex Figure 10

Clinical guidelines for the major areas of BPHS health services are available at the health facility. Of the 180 health facilities, 2% have a complete set of the clinical guidelines related to BPHS. To meet this standard, the following guidelines are required:

1. Maternal & Newborn Health
    - Antenatal care
    - Delivery care
    - Postpartum care
    - Family Planning
    - Care of the newborn
2. Child Health & Immunization
    - EPI services (schedule of EPI for Afghanistan)
    - Integrated Management of Childhood Illnesses (IMCI) guidelines
3. Public Nutrition
4. Communicable Diseases
    - Treatment of TB
    - Treatment of malaria
5. Essential Drugs (A list of essential drugs for the type of facility and guidelines for their use should be available to staff).

If any of the guidelines are unavailable at the facility, the person in charge should request the NGO to supply them as soon as possible. Where national MOPH guidelines are available, these should be used; if they are not available, the NGO should supply the most up-to-date guidelines available.

For this standard, the FFSDP scoring system allows for separate scoring for each of the five areas of BPHS (20 points for each area), for a total of 100 points. This flexibility in scoring allows calculation of the average number of points for the availability of guidelines in all the health facilities. This average is low at only 18 out of 100 points.

Annual and monthly goals for health care delivery have been calculated. Only 1% of the 180 health facilities had at their disposal the annual and monthly goals for BPHS delivery in their catchment area while all NGOs grantees have performed a baseline household survey allowing for an estimate of the annual and monthly goals. The ample technical assistance REACH has provided to the NGO headquarters should, in turn and as soon as possible, be replicated by the NGO headquarters for the health facility staff.

Coverage Monitoring is up to date for the last month for the following services:

- Antenatal Care
- Postnatal Care
- Tetanus immunization of pregnant women
- Institutional Delivery
- Family Planning
- DTP3
- BCG

For this standard, the FFSDP scoring system allows for separate scoring for each of the 7 areas of BPHS (5 points for each area), for a total of 35 points. Of the 180 health facilities, not one had a graph for monitoring each of the seven services listed above.

Using the graph forms and estimates of target groups that UNICEF provided, 12% of the health facilities have graphs for monitoring the EPI activities (tetanus immunization of pregnant women, BCG and DPT3).